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NOVEMBER, 1970

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THE HAMPDEN HIPPOCRAT
·1942·

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A bulletin for
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The Massachusetts
Medical Society

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EDITORIAL

P.S.R.O. — ANOTHER SLEEPER?

Will we soon be saying: "Here we go again?" Is the Kerr-Mills' game plan, as initiated and supported by the AMA and which finally resulted in the fiasco called Medicaid, going to be repeated again? Such seems to be the "handwriting on the wall."

BIRTH AND DEVELOPMENT

Last June the AMA's House of Delegates in pushing the Medicredit bill, an alternative to the growing clamor for a national health insurance plan, endorsed the concept of a peer review organization (P.R.O.) to sweeten the offering. This AMA tidbit proposed that the Secretary of H.E.W. contract with state medical societies, or an organization designated by a state medical society, to establish and operate a peer review organization in each state. The state group would appoint a commission to administer the program as well as an advisory council. This state commission in turn would appoint local panels "to review the need for and quality of medical services furnished under federally supported programs and the appropriateness of charges for such services." The idea was that doctors would pass on the services rendered by doctors. To push this concept, the AMA approached Senator Wallace F. Bennett (R., Utah), a "friend" slated to become the ranking Republican next year on the Senate Finance Committee, which is responsible for processing tax-based health legislation in the Senate. Bennett thought well of the proposal and more so since it came from the medical fraternity itself. It was then forwarded to the Finance Committee's staff, who commented that the AMA plan was "unduly limited" and suggested that it be expanded.

A FRIEND IN NEED

The tough-minded members of the Finance Committee's staff, desperately looking for ways to control Medicare and Medicaid costs without imposing direct federal controls, suddenly found manna from heaven cast into their laps. This same committee's staff, after castigating every segment of the health care industry in a report submitted earlier this year on Medicare and Medicaid abuses, opportunely had handed to it a vehicle for developing a plan to avoid such alleged abuses under the dressing of a peer review system. Moreover, appropriately drawn up and implemented, this concept could and would indeed be most salacious since ensuing censures could be cast at the feet of physicians and health professionals rather than politicians and governmental bureaucrats.

Concerned with rising hospital costs as well as with physicians' fees and enthusiastically encouraged by the Californian medical foundations' claims of substantial reductions in Medicaid costs, the Senate Finance Committee's staff came up with a more comprehensive proposal for review of all patient care, including broad controls over institutional utilization. Thus was born the so called "Bennett Amendment" or the Professional Standards Review Organizations (PSRO) amendment to HR 17550, the Social Security amendments bill.

WHAT NOW

At first, the AMA was a little chagrined at what had been done to its original

proposal but felt somewhat committed to go along with the plan. After all, what's wrong with peer review? Physicians will be reviewing physicians, and medical societies would be in charge. Only the job would be much bigger than originally contemplated. But storm clouds were gathering to indicate that the peer review proposals were getting out of hand.

The American Hospital Association was first to react as being vehemently opposed. Not only did the AHA oppose the AMA's original proposal (PRO), but also the PSRO proposed by Senator Bennett. First of all, the AHA would retain peer review of hospital cases in the hands of hospital medical staffs rather than in the hands of medical societies especially since the majority of practicing physicians by far have hospital medical staff ties. Moreover, the AHA believes "this legislation to be the most extreme invasion of private practice of medicine in history." PSRO requires "the maintenance of profiles and constant review of every patient, every physician, and every institution." PSRO gives authority to invade the privacy of the physicians' and hospital medical records and to inspect their facilities and services." "The legislation will cost more than any potential saving." "It is in effect government control of medical practice, with the county medical society acting as the government's agent." Dr. Ainsworth, spokesman for the AHA, further charges that the PSRO amendment "sets up present and future control mechanisms which could achieve ultimately powers to control all aspects of health care in the U.S. to the exclusion of any voice for the practicing physician, the hospital, allied health professions, or the patient."

Superficially, this might look like a power struggle between physician organizations and hospitals relative to the control of medical practice. However, the AMA is taking a second look at what its brain child has become after its nurturing by a legislative brain trust. The AMA is still for motherhood and the peer review concept; however, the PSRO seems to be developing into an unwanted child.

The peer review principle is indeed a most rational approach to the control of utilization, quality, and cost of medical services. Professional services, whatever they may be, should and must be evaluated by professional peers. The only problem therewith is how to implement it so that it is effective. Health professionals must get together and repress their respective ambitions for familial supremacy and domination. A workable plan and program based on peer review must be developed and implemented. Physicians, as traditional captains of the health, must assume their rightful role as leaders but always realizing that it is the team and not the individual that plays the game and wins.

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PRESIDENT'S PAGE

COMPULSORY NATIONAL HEALTH INSURANCE

The swing of the pendulum in the direction of increased interest in compulsory health insurance for all Americans is bound to enhance the feverish activity of the 1972 presidential candidates and planners at all levels of health care distribution.

Time magazine has used its crisp literary style to cloak with authority the estimates by Max Fine of the Committee of 100 that $1 billion would be saved annually by restructuring the conduct of private health insurers. According to Fine, another $6.4 billion would be saved by eliminating doctors' overcharges and unnecessary surgery.

Proponents of the bill estimate a first year cost of $57 billion while the Administration's John Veneman estimates this cost to be $77 billion.

After hearing Walter McNerny, Dr. James R. Kimmey, Dr. John Knowles, and Dr. Soutter and others in separate presentations in recent weeks, there seems little doubt that great momentum has built up toward discussing if not solving the problem of distribution of health care.

As we move into the immediate years ahead, there is a need for physicians to try even harder to correct sincere misinformation which often occupies the minds of lay members of health planning groups. Some examples are: the computer expert who thinks he can predict the exact needs and costs of health care even in a community, to say nothing of a nation; the actuarial figures which vastly underestimated medicare and medicaid costs; or the regional radiation therapy planners who fail to consider that the per day ambulance charges are in excess of the basic radiation therapy cost daily in long term transfer problems.

Politicians will be harder to influence by facts and experience because in national health insurance legislation they tend to the belief, "Thar's votes in them thar bills."

The HDMS has both a general interest and open channels of communication through its Public Relations Committee headed by Dr. Bernard Gilchriest and the Interhospital and Community Health Planning Committee headed by Dr. Bandeian. Let us all make our contribution to these good works and respond as individual physicians concerned about better health care.

John W. Turner

John W. Turner, M.D.

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FUTURE PORTENTS

PUBLIC HOSPITAL PROBLEMS

The plight of almost all public hospitals in this nation consists of under-financing, insufficient staffing, administrative bureaucracy, and obsolescence. This is a manifestation of one aspect of the crisis affecting American social institutions. Specifically, three major problems confronting public hospitals today are, being out-of-step with modern social philosophy, under-financing, and lack of authority for self-determination.

There is an ever growing consensus that medical care is no longer a privilege but a right. As a corolary to this, the double standard system of medical care has become discredited. The concept of adequate and equal medical care is taking hold and thereby breaking the public hospital's monopoly on health care of the poor. Popular expectations are demanding decency, reasonable amenities, and technical competence in the medical care provided by public hospitals.

Some health planners and policy makers would write off public hospitals as being vestigial in the light of new policies and programs being drawn up to implement the demand for equal access and equal standards for medical care.

New federal and third party payee programs seemingly tend to allow voluntary hospitals to take over the functions of public hospitals or to allow the latter to become self-supporting voluntary hospitals. A single level and a single standard of medical care for everybody is the goal. This ideal has not yet been realized but hopefully will come in the near future with the public hospital assuming its rightful role as a facility for all segments of the community.

Public hospitals have been and are chronically under-financed because the body politic does not fully understand their functions nor renders them adequate support. The need and cost for local public services have skyrocketed over the last 30 years. Property taxes have risen precipitously and competition for the local tax dollar amongst various services of local government

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HDMS-SAM Joint Meeting, December 8.
HDMS-Executive Committee Meeting, December 15 and January 19, 1971
MMS Council Meeting, Boston, February 10, 1971.
MMS Annual Meeting, Boston, June 1 – 3, 1971.
American Academy of Dermatology, Chicago, December 5 – 10.
American Association for the Advancement of Science, Chicago, December 26 – 31.
AMA Annual Meeting, Atlantic City, June 20 – 24.

has become more than fierce. Hospital costs have also increased but public hospital budgets have not been increased in proportion as the budgets for other governmental services. This in spite of the returns yielded by federal, state, and insurance carrier reimbursements. In many instances payments from Medicare and Medicaid have been treated as a windfall for the property taxpayer rather than a means of shoring up public hospital finances. Heavily burdened taxpayers and worried city fathers have been enchanted and enraptured with the fallacy that the public hospital is a dead-duck because now the voluntary hospitals and for-profit facilities can and will take over the responsibility and will do it better and cheaper. But with whose money obtained from where?

Another difficulty for public hospitals is the increasing constraint imposed on administration by the overburdened bureaucracy of local government; a constraint that is supposed to ensure honesty and economy but which really ensures only strangulation and chaos. City governments are staffed with expert functionaries in such areas as personnel, accounting, budgeting, purchasing, maintenance, etc. These functionaries insist upon complete control of the public hospital's activities as such relate to their domain of responsibility. In almost all instances, public hospitals are legally set up as an operating department of a local unit of government and therefore are subject to various legal regulations that affect acts of public agencies and public officials. This means that the management of the public hospital is usually greatly fragmented, cumbersome, and dependent. It is likened to a situation where many can say "no" to the hospital but almost no one can say "yes." In other words, instead of being able to react fast to changing situations, the institution is tethered by regulations and bureaucracy. Moreover, decisions pertaining to quantity and quality of medical care are dictated by the funds made available rather than by the services needed. If public hospitals are to assume their rightful place in the health care delivery system of the community as health care needs apparently are demanding, they must overcome their isolation and traditionally binding inertia. Segregated health care for the poor must go. Improved governance and adequate financing is a must with freedom from strictures of local government bureaucracy.

SOLUTIONS

The problems of public hospitals are varied but experiments in the solving of these problems share a commonality, namely, the circumvention of politically imposed fiscal inadequacies and bureaucratic restrictions. Functioning autonomically, voluntary hospitals have made great strides in the last two decades by being able to appoint enlightened trustees to their boards, de-

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termine their own priorities, develop capital funds, control their budgets, hire and fire professional and non-professional staffs, and purchase equipment, supplies, and services competitively. Moreover, they have been able to react rapidly to changing circumstances because of the inherent flexibility in their organization and administration. In contrast, public hospitals have been granted few of these prerogatives necessary for the provision of high-quality medical care. They have been strapped with massive deteriorating physical plants, purchasing practices beset with bureaucracy, personnel practices bound by civil service regulations, and inflexible budgets. Added to this has been the identification of public hospitals as "dumping grounds" and the last resort for the unwanted medically indigent with a dual standard of medical care delivery. All this has led to a situation that is not only intolerable to those associated with public hospitals but also to accrediting agencies. Moreover, since public hospitals provide a large portion of medical care in this nation which could not be absorbed by voluntary and for-profit institutions, there is no alternative but to revitalize public hospitals by placing greater control in the hands of professionals and separating the authority for the hospital from the body politic.

A variety of experimental arrangements are being tried out throughout the country in this movement to revitalize public hospitals. These include (1) an affiliation with a medical school, (2) the creation of a "public benefit corporation," (3) the establishment of a direct governing commission, or (4) transfer of the hospital's management to the voluntary sector. In some instances a combination of these approaches has been attempted. Affiliation with a medical school seems to have produced the greatest advantage for ailing public hospitals, by bringing good established administration, more capital funds, flexibility in budget control, autonomy, as well as expansion and improvement in services. Governing commissions with only titular responsibility for operation of a public hospital and without operational control over the budget and personnel policies can accomplish little to nothing; but with autonomy, much progress can be made.

Examples of what is happening in Massachusetts can be seen in the case

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HAMPSHIRE DISTRICT MEDICAL SOCIETY

TIME: **Tuesday, December 8, 1970**
Business Meetings at 6:00 P.M. followed by
Social Hour at 7:00 P.M.
*Dinner at 7:30 P.M. (Courtesy for members of Hampden)

PLACE: **Storrowton Tavern**
Stagecoach Barn
West Springfield, Mass.

SPEAKER: **Lamar Soutter, M.D.**
President of Massachusetts Medical Society
Dean, University of Massachusetts Medical School

YOUR PRESENCE IS URGENTLY REQUESTED

Charles Atamian M.D.

Charles Atamian, M.D., Secretary, SAM

Setrag A. Zacarian, M.D.

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Donald B. Rogers, M.D.

Donald B. Rogers, M.D., Secretary, HDMS

*If you must cancel your dinner reservation, please do so before noon on December 8, 1970.

of the Haverhill Municipal Hospital, whose administrative control has been transferred over to the voluntary sector and the Boston City Hospital, where operation thereof under a charitable corporation is being considered. In the latter instance, the Board of Trustees already has been incorporated by statute to receive and hold real estate and personal estate granted thereto up to 10 million dollars. Moreover, the said corporation can contract with or accept gifts from almost anyone and has the authority to hold and expend any funds received under contracts, grants or gifts. The authority of this corporation is so broad as to allow the City of Boston to contract with the corporation to operate all the City's hospitals and the health department; this is being studied now.

SPRINGFIELD MUNICIPAL HOSPITAL'S STATUS

Insofar as the Springfield Municipal Hospital is concerned, the situation is not desperate as yet, but storm clouds have been and are gathering since many, if not most, of the ingredients for crisis as faced by other public hospitals are at hand. The Hospital is dedicated to the double standard of medical care by an enabling statute ("charter") which precludes admission to anyone other than the sick poor. Therefore traditional segregation of the sick poor, sanctioned and encouraged by law, is perpetuated contrary to currently envolving social philosophy as exemplified by Medicare and Medicaid. Secondly, the Hospital is under-financed and under-staffed; moreover, it is bound by strangulating bureaucratic controls beyond the powers of its titular governing body to influence. There it stands, a health resource isolated from the mainstream of the community's health delivery system with little incentive or potential for developing extra-hospital relations or for promoting continuity of care. Bound by tradition and inertia it is unable to innovate or to experiment with new methods. Should current circumstances persist, a crisis will be at hand in the light of currently envolving licensing and accrediting standards.

In spite of the commonality of problems facing the Springfield Municipal Hospital and many other public hospitals, certain fortunate circumstances have kept the wolves from the door so far. Through the gigantic efforts of a small but dedicated and loyal staff, the quality of care rendered has been high as attested by the recent accreditation from the Joint Commission for Accreditation of Hospitals, and relicensing by the Mass. Department of Public Health. The plant is relatively new so that obsolesence is not a problem, although deterioration is beginning to show some marks. Overcrowding has been avoided by admitting only the numbers of patients which the existing staff can handle properly and with safety, comfort, and convenience. However, all this is merely a holding action which cannot

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be maintained indefinitely and the flood wave is soon to come. The dedicated, loyal staff is decreasing and similarly qualified replacements are virtually impossible to recruit. Costs are increasing! Licensing and accrediting agencies are demanding more and more in terms of services and standards. Third party payees are carefully scrutinizing the need for skilled *medical* care and increasingly refusing or threatening to refuse payment when *medical* care needs requiring skilled services and personnel cannot be documented to their satisfaction. Moreover, third party payees are demanding better administrative practices to justify costs of services.

In the light of the aforesaid, the time has come for a close scrutiny of the role of the Springfield Municipal Hospital in the community's health delivery system, its policies, its organization, its methods of operation, and its financing; so that it can make an optimum contribution to the medical care needs of the community in concert with all other community health resources and in keeping with modern standards. It must not be allowed to stand or become a "dumping ground," "a warehouse," and a stop-over on the way to the grave for the unwanted sick poor of our community. It has too much to offer to each and every member of our community in terms of providing the best in needed medical care services at and for the right time and at the right price.

As a beginning, there should be a clear definition of the Springfield Municipal Hospital's mission in the total community's health care delivery system. In other words, a precise statement should be made as to type, scope, and amount of services to be provided for a limited but optimum period of time. Personally, such services should be comprehensive in that medical care is provided by and under an organized medical staff and includes continuous skilled nursing care, restorative services, dietary services, social services, and other services to patients who must show potential for rehabilitation or improvement to a stabilized condition or have a deteriorating condition requiring intensive care and services. Secondly, these services should be available to each and every member of the community needing such services irrespective of who pays the bill and not exclusively to the "sick poor." Lastly admission and length of stay must be justified on an impartial determination of *continuing medical care need*; moreover, this must be documented by periodic personal physician certification and peer utilization committee review. The maximum length of stay should not exceed 6 months in any case. All patients who have attained maximum benefits from restorative services or have reached a stabilized state, must be discharged as soon as possible to health care facilities offering lower lev-

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els of care or to a home health care program for continuing care, if and when necessary.

In such a role as described above, the Springfield Municipal Hospital would provide a sorely needed program in this community where there is a tremendous void or at best a highly inadequate and greatly fragmented one. As a fringe benefit, beds could be freed up in acute short stay general hospitals of the community, thereby, negating the need for building and operating such expensive facilities. As for the patients currently in the Hospital, each case could be evaluated and transferred to an appropriate facility offering lower levels of care but consistent with the patient's needs. This weeding out process could be carried out gradually and through attrition.

When and if such principles are wholeheartedly accepted, then a complete reorganization of the Hospital becomes a must to efficiently implement same. Complete autonomy and authority must be vested in the governing body of the institution either through an affiliation, the creation of a public benefit corporation, the establishment of a direct governing commission, or the transfer of the hospital management to the voluntary sector via a lease of sorts or an outright sale. The possibility of attaining autonomous authority through affiliation with a medical school is remote. This leaves the three other possibilities. Should the City's government decide that a commitment on its part is necessary, then the mechanisms of "a public benefit corporation" or a direct governing commission might be entered into. Patterns for same are readily available. On the other hand, if the City government feels that no commitment is necessary or desirable on its part, then transfer of the Hospital to the voluntary sector would be the answer.

In any case, requirements and demands by the public, by various governmental programs, by licensing and certifying agencies, by accrediting organizations, by insurance carriers, and by official and unofficial health planning organizations are and will increasingly bring pressure to bear on bringing about the redefining of public hospital goals, policies, organization systems, procedures, and methods. The budgets of public hospitals will of necessity have to be increased but efficiency will also be increased through such controls as stringent utilization monitoring and cost finding techniques with appropriate remedies being applied.

The Springfield City government and all locally related health care resources must start now joining hands in bringing about changes to make available the Springfield Municipal Hospital's resources to the greatest and best benefit of the whole community. The crisis which is coming will not only befall the Springfield Municipal Hospital, but will also reflect upon the entire community — individuals and institutions.

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Since 1960, according to the latest U.S. cost-of-living (C-of-L) report, hospital daily service costs increased 160%. During the same decade the weekly paycheck rose 52% while physicians' fees increased 58%. To complete the picture, it is interesting to note that housekeeping help and room repainting increased 70 and 90% respectively while indoor movies jumped to 102%. Here is how some of the comparative costs look in tabulated form. (Based on figures published in the *Wall Street Journal* of October 19, 1970.)

	1960	Now	Chg.
C-of-L, All Items	103	136	32%
C-of-L, Commodities	101	126	24%
C-of-L, Services	106	156	47%
Weekly Paycheck	$ 80	$122	52%
Property Insurance Rates	104	155	50%
Repainting Rooms	106	200	90%
Re-shingling Roof	108	170	57%
Housekeeping Help	111	189	70%
Physicians' Fees	106	168	58%
Dentists' Fees	104	153	47%
Hospital Daily Service	112	292	160%
Movies, indoor, adult	108	218	102%
Movies, indoor, children	115	240	108%

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HOW MANY "OPEN-HEART" CENTERS?

Most of the escalation of hospital costs is understandable: more and more employees, higher and higher salaries and an ever-increasing variety of facilities to serve the health of the public. There are, however, some hospital expenditures that raise doubts in the minds of many. For instance, how many hospitals do you estimate, are equipped to perform open-heart surgery in the United States? 200, 300 or 400? Well, according to a 1967 HEW survey, the answer is an astonishing 777. But this isn't all. The survey further showed (a) that fully one-third of the hospitals surveyed had no "open-heart" cases at all that year; (b) that more than 60% had fewer than one a week; (c) that 30% had fewer than one case a month. New York City, another report showed, has about a dozen "open-heart" centers, but practically all the operations are performed by three or four of the hospitals. It is generally agreed that for sheer competence and effectiveness the existence of an "open-heart" facility is justifiable only if its services are utilized at least once a week.

The inescapable conclusion is that we are encumbered with many more "open-heart" centers than we can use. At least one-half of them could be shelved; better still, they never should have been established in the first place. They constitute a tragic waste of dollars, sophisticated gadgetry, and trained personnel. Some of them were motivated, perhaps, by a hankering for prestige and glory. Perhaps, they were prompted by a desire to emulate or even to surpass other hospitals. Dr. Osler most likely would have included this type of extravagant ostentation in his list of examples of "medical chauvinism." The bulk of the expendable "open-heart" centers, however, is undoubtedly the result of miscalculation or faulty planning on the part of all concerned — hospital trustees, administrators and medical staffs.

MILESTONE OR MILLSTONE?

Is there need in this area for an "open-heart" center? For a kidney-transplant unit? Etc., etc.? Should one, two or more hospitals establish one and the same elaborate and expensive facility? It was dilemmas of this type that prompted the recent organization of The Connecticut Valley Health Planning Council, Inc. The objectives of this organization are sound, its opportunities are many, but its responsibilities are grave and serious. It may not affect the physician personally, but it may well affect the nature and quality of the care our patients are to receive. There is always the danger that non-medical leadership and obsessive penny pinching will deprive the public of many of the benefits modern medical progress has to offer.

It is imperative, then, that our profession become much more actively involved in area health planning than it is at the present time. The voice of the two physicians now serving on the Board of the Council is altogether too feeble to influence either policy or decisions. The most they can do is to serve in an advisory capacity. Their effectiveness is highly questionable. It should be noted that similar concern was expressed in this column as far back as eighteen months ago when the Council first came to light: "One example is the recently established Connecticut Valley Health Planning Council whose Board of Directors consists exclusively of laymen. Oh, yes, there will be a medical advisory committee, but this, as we all know, is sheer window dressing. Medical decisions and policy making will, as usual, remain firmly in the hands of the lay Board of Directors." (*Hippocrat*, March, 1969)

Millman

MEDICAL MALPRACTICE

by Richard P. Bergen
Director, Dept. of Legal Research
Office of the General Counsel American Medical Association
(concluded)

MEDICAL MANPOWER SHORTAGE

But if contingent fees aren't the cause of high malpractice premiums, what are the causes? One cause is the medical manpower shortage. The patient load of the average physician has been constantly increasing over recent years. Our affluent economy, and insurance and governmental welfare programs have increased the ability of the public to pay for medical services. The more units of patient care the physician provides, the more he is exposed to the risk of a malpractice claim. By the law of averages, if a doctor treats more patients, there will be more incidents of injury suffered by a patient. Each injury is at least a potential malpractice claim.

LEVERAGE

The foregoing factors, of course, apply to a greater or lesser extent to all fields of liability and liability insurance. There are differences of degree, but not enough to explain the differences in rates of premium increases. The distinguishing factor here, I believe, is "leverage". Many doctors and lawyers know about leverage in investment, but they may not realize that it also applies with disadvantage in malpractice insurance.

The leverage factor arises because malpractice insurance premiums are paid by a relatively small group of approximately 200,000 physicians engaged in patient care, who provide medical service to approximately 200,000,000 patients. Since each patient is a potential malpractice claimant there is a leverage factor of more than 1,000 to 1. A relatively small increase in the average cost of claims is translated into a dramatic increase in premiums. This is not typical of most liability insurance. In automobile liability insurance, for example, the number who pay premiums is, at least a third of the total population who represent potential claimants. The leverage, therefore, is only 3 to 1 — relatively insignificant.

But cost of premium is not the heart of the problem. Lawyers in the personal injury field, whether plaintiff or defense oriented, find it difficult to understand why physicians make so much commotion about premium costs. As they

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look at it, these are normal costs of doing business and are passed on like other costs in the price of the services sold. They see physicians as being in an ideal position — able to pass on such costs without substantial difficulty. To the lawyers this is the operation of the social principle of spreading the cost for compensating patients over a large population through insurance.

In a sense they are right. In 1968 it is estimated that the total malpractice insurance premiums paid by physicians was approximately $75,000,000. In the same year a fee of 50 cents a day per hospital bed would have resulted in a fund of over $150,000,000 a year. The total premium spread over the total number of units of patient care rendered that year would have amounted to an insignificant charge per unit of care.

POSSIBLE UNAVAILABILITY

The serious danger that is the real cause for concern is the looming possibility that some day physicians will be unable to obtain malpractice insurance at any price. Many physicians in various parts of the country had a fair taste of that crisis in the last few years. Temporarily the problems were finally solved, but I don't think that any of those who were notified that coverage would no longer be available will ever forget that experience.

This danger arises because malpractice insurance is not an attractive business risk. Insurance companies have an obligation to their stockholders to operate at a profit, or in the case of mutual companies to operate in the best interests of all their policy holders. If one line of insurance, such as malpractice, is continuously operated at an underwriting loss there is strong motivation for the company to drop that line. Some companies have already left the field and the others are trying to be more selective in accepting risks.

Nobody loves an insurance company and I am sure that is true of most physicians and lawyers. I don't have too much affection for them myself. From figures and reports I have seen, however, I am convinced that all companies have had sharp underwriting losses for the last five years, at least.

It is true that insurance companies don't talk very much about their investment income. I look out of the window of the AMA headquarters in Chicago and can't avoid seeing the John Hancock building sticking up in the sky as a monument of insurance investment. Despite my prejudice, however, I have been convinced that in the malpractice field underwriting losses have greatly exceeded any possible investment income. Life and fire insurance and other lines may have shown a profit, but not malpractice. Moreover, as a hard headed business proposition, why should a company continue a line at an underwriting loss if it can break

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even or show an underwriting net in other lines?

With the new round of premium increases, it may be that the insurance companies will break even this time. At best, however, they won't know how well they guessed on premiums for 1970 until five or six years have passed. This is what is known in the industry as the long tail on malpractice. It takes five or six years before the 95 percent of the claims for a given year are closed. Moreover, the tail is getting longer as more courts adopt the "discovery" doctrine under the statute of limitations. This leaves the doctor and the insurance company exposed to suit for a virtually indefinite period.

In the situation that exists today no physician can afford to practice medicine without insurance protection, unless he happens to be judgment proof. In my opinion, physicians owe a debt of gratitude to insurance companies that continue to make it possible for them to practice medicine.

PHYSICIAN-PATIENT RELATIONSHIP

From a human point of view a more distressing consequence of the malpractice crisis is what it does to the physician-patient relationship. The litigation explosion and skyrocketing cost of liability insurance create an unhealthy situation.

If something goes wrong in patient care with adverse results for the patient, the instinctive response of the physician is to do everything he can to restore the patient to good health. This instinctive response, however, is blunted by the overwhelming burden of the existing tort litigation and liability insurance structure.

The minute an injury is recognized which might lead to a damage award, this burdensome structure converts the physician from a trusted guardian of the patients life into a legal adversary. At that moment the lawyers on both sides become potentially interested in what happens. The physician is advised

to be careful of what he says to the patient or his family, lest what he says be interpreted as an admission of fault. He must notify his insurance carrier promptly or risk loss of his insurance protection. He realizes that everything he has said or done or will say or do will be gone over with the fine tooth comb of the legal profession, looking for faults. This frightening burden for the physician certainly cannot be for the best interest of the patient.

At present, the best hope to keep coverage available appears to be an insurance program sponsored by the state society jointly with AMA. We at AMA headquarters are working on the development of procedures to assist state societies in establishing effective programs under AMA leadership. The key to success is unified support of these programs by AMA members. Doctors must recognize that low price alone is not the best determinant of a good insurance program.

PATIENT SAFETY

The area of accident prevention and patient safety is also receiving increased attention. Every malpractice claim is based on some injury or unsatisfactory result arising out of patient care. Any reduction in patient injuries will bring a reduction in claims. Most physicians practice good medicine but still patient safety can be improved. It can be done, however, only if individual physicians cooperate. Doctors, when safety programs are instituted at your hospitals, don't oppose them but support them and make them work.

Insurance people tell me that a substantial number of malpractice judgments arise from physicians attempting procedures at the upper limits of their range of professional competence. This, of course, should be discouraged. It can be best controlled by physicians at the local hospital level. AMA is currently encouraging regulation of staff privileges through effective peer review. Here again is an area in which cooperation of physicians is essential.

EXPENSIVE AND INEFFICIENT SYSTEM

It is daily becoming more evident that personal injury litigation is an expensive and inefficient method for distribution of compensation to injured persons, particularly in malpractice claims. Roughly 27 cents of every malpractice premium dollar is all that is received by injured patients to compensate them for their injury. Roughly 44 cents of every dollar pays for legal fees and expenses of both sides. This clearly shows that the tort-litigation liability insurance structure is an excessively expensive and inefficient way to provide just compensation to injured patients. Unless changes are made, every indication is that the system will continue to become more expensive and more inefficient.

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To the doctors and to the man on the street, it certainly appears that the lawyers are getting too big a cut of the pie. I am the last one to downgrade the value of legal services. I believe that lawyers, like doctors, are worth every cent they are paid for their professional services. If anything, the services are worth more than they cost.

The question does arise, however, of whether there may not be an over-utilization of these highly valuable legal services. Isn't it possible to devise some way by which a larger percentage of the insurance premium dollar can go to the injured claimant without the need for expensive legal services at every step of the procedure? I think that there must be and that it will be found sooner or later.

The tort litigation liability insurance structure has been a profitable source of livelihood for a large segment of the legal profession. It is understandable that lawyers who derive their income from this source are reluctant to have anyone tinker with it. I believe, however, that farsighted lawyers must realize that if the trend toward increasing expensiveness and inefficiency are permitted to continue, the legal profession will be killing the goose that lays the golden legal egg. Therefore, I urge the legal profession to bend every effort to develop a better, more equitable and less expensive system to replace that which exists today.

Lawyers who hear doctors complaining about malpractice and malpractice insurance may get the impression that the doctors would like to do away with lawyers altogether and to obtain total immunity from liability suits. Maybe there are a few who are that extreme, but it would certainly be a distorted impression for the medical profession as a whole.

Physicians are truly dedicated to giving their patients the best possible care. They try their best not to injure any patient and if any patient is injured through their fault they want him to receive just compensation. They recognize that, in the long run, the cost of malpractice insurance is paid by the patients. They acknowledge that lawyers are necessary and useful where questions of liability are uncertain and difficult to determine. They resent the threat of the ordeal of a malpractice trial which constantly hangs over their heads like a sword. They are increasingly concerned with the wastefulness and irritation of the present system. They don't ask for a system that will be all for the benefit of themselves and no benefit to anyone else. What they really want, in my opinion, is a new, efficient system that will be fair to patients, fair to lawyers and fair to the medical profession.

If our two professions don't develop a better system, it is certain that the federal government will eventually impose a new system. The history of government attempts to solve problems convinces me that it is better to find solutions in the private sector. When the legal profession accepts its responsibility for developing a system better than the current tort litigation, liability insurance structure, I am confident that it will find the medical profession ready to cooperate.

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MMS COUNCIL MEETING HIGHLIGHTS

The stated meeting of the Council of MMS was held in Boston on October 14, 1970 with the meeting being called to order at 10:12 A.M. by the President, Dr. Lamar Soutter. Representing the HDMS were the following councilors: Drs. J. D. Allan, A. G. Asinas, J. C. Ayres, G. Cox, II, L. F. DeRose, E. F. Franseen, J. J. Gallagher, B. N. Gilchriest, J. R. Kelly, and R. N. LaMarche.

FEES

Matters pertaining to Blue Shield and fees were taken under consideration as the first order of business. Dr. Soutter reported on the activities of the subcommittee of the Executive Committee which had been appointed to consider the Middlesex East resolution concerning the re-evaluation of Blue Shield Participating Physicians' Agreement and the Hampden and Bristol South resolutions, dealing with amendments to the statutes to provide payment to patients using services of non-participating physicians. The basic changes proposed in the Physician's Agreement by the Executive Committee are as follows:

(a) A provision has been added to the preamble which calls for prior approval by the Voting Members of the offering by Blue Shield of any subscriber contract which does *not* provide for payment on the basis of usual and customary charges.

(b) Revised paragraph one deletes reference to payment on the Unit System in accordance with a fee schedule now on file or as subsequently modified or amended. Substituted is a requirement that payment be on the basis of usual and customary charges, but continuation of payment under present fee schedule contracts until their termination is permitted.

(c) Present paragraph two which provides for reduced payments on a pro rata basis in the event insufficient funds are available has been deleted in its entirety.

(d) Revised paragraph three defines "usual and customary charge," including a provision that the range of customary charges must include at least 90% of the usual

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fees for a given service, instead of 83% as at present. It also makes reference to economic areas whereas the present contractual definition refers to the Commonwealth of Massachusetts as a whole.

(e) Revised paragraph three extends from thirty days to one year the deadline for reporting services rendered without possible penalty.

(f) Revised paragraph four reduces the hiatus between notice of termination and effective date of same from twelve months to three months.

(g) Revised paragraph five eliminates the waiver of the right of the physician to recover monies previously due him if termination is for cause other than relocation.

(h) Revised paragraph six adds the requirement that the physician be notified of all changes in by-laws or rules and regulations.

(i) A new paragraph seven has been added. It provides for an annual review of the Agreement by the Executive Committee or a subcommittee, and for mutually acceptable amendments thereto.

Dr. Soutter pointed out that no final report could be made to the Council until discussion on these changes had been carried on with Blue Shield. Upon recommendation of the Executive Committee the Council voted to accept this as an informational progress report.

Dr. Soutter then went on to explain the mechanism of payment by the physician's profile. Although the customary range of fees for a given procedure was placed in the computer in 1967, a physician's own profile was not put in the computer until 1969. It is possible that a physician might have received a higher fee prior to the application of his profile than after because the number of procedures done at a lower charge was greater than the number at the higher charge. Furthermore, the profile will only be updated periodically with profiles being currently updated as of August, 1970. Dr. Soutter noted that this irregularity in payments has caused some discontent among physicians but that Blue Shield is trying to improve methods of payment with their new computer program. Moreover, the MMS Interspecialty Committee is working on a relative value guide which, if adopted and generally used, might cause less discontent. In view of the aforesaid plus the fact that it would be unwise both for the physicians and the public if MMS withdrew its support of Blue Shield, which might be in essence the effect if payments were made to patients for services of non-participating physicians, the Council voted to approve the

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Executive Committee's recommendation "that for the present the status of the non-participating physician remain unchanged."

The next item considered had to do with geographic variation of fees. Upon intensive review of the circumstances, the Committee on Prevailing Fees came up with the following recommendations in determining the level of usual and customary physicians' charges in Massachusetts:

(1) "A single statewide geographical area should be used rather than multiple arbitrary geographical subdivisions of the state.

(2) Third party agencies should be asked to accept the format of the Mass. Relative Value Schedule as soon as such is approved by Council.

(3) The MMS should establish a committee which, in consultation with interested third parties, shall consider and define basic conversion factors to be applied to this Relative Value Schedule and shall define any reasonable variations in such conversion factors."

The recommendation of the Executive Committee to approve this tripartite resolution from the Committee on Prevailing Fees was voted in the affirmative by the Council, but only after considerable debate and warm discussion.

In a communication from Blue Cross, it was brought to the attention of the Council that the Mass. Hospital Association calls for utilization review of Blue Cross patients according to the Medicare approach. However, before implementation of such a program, a study including an appropriate body of the MMS, the Blue Shield, and representatives of consumers' interest must be carried out in depth and broadly so as to bring about an improved approach equitable to patients, physicians, hospitals, and Blue Cross. It is envisioned that an outgrowth of the study would be a program of certifying and re-certifying the need of a Blue Cross patient for continued care within a hospital. The Council voted approval that an appropriate body of the MMS participate in this study of utilization review under Blue Cross.

ABORTIONS

The Committee on National and State Legislation, feeling that several bills would be filed on the subject of abortions for consideration by the 1971 Legislature, recommended for its own guidance that the Council adopt the resolution passed by the House of Delegates of the AMA on June 25, 1970. It was pointed out that currently termination of pregnancy by medical abor-

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tion is apparently legal in Mass. under certain circumstances. Past rulings of the Mass. Supreme Judicial Court with Sections 19 and 20 of Chapter 272 of the General Laws in mind, allow that "therapeutic abortions can and are being performed in hospitals of high standing throughout Mass. After medical consultation." Aside from some feelings expressed regarding the morals and ethics of performing therapeutic abortions, it was pointed out that the current situation in Mass. is such that pertinent decisions regarding thereto are in the hands of physicians and are not subject to statutory edicts; hence, there was no need at this time to change the status quo. Moreover, it was felt that the AMA's resolution was somewhat ambiguous and needed clarification and expansion. A motion to table this recommended resolution was carried by majority vote of the Council.

OTHER ACTIONS

The Council voted that the 190th Anniversary Meeting of the MMS be held at the Statler Hilton Hotel in Boston, on June 1, 2, and 3, 1971. Secondly, the Annual Meeting of the Council is to be held on Wednesday, May 26, 1971.

The Committee on Medical Services recommended that the resolution referred to it pursuant to May 20th Council meeting and pertaining to the withdrawal of all American troops from Indochina was not primarily concerned with medical affairs and, hence, inappropriate for the Council to take a stand thereon. In accordance with the recommendation, the Council turned down the resolution.

The Committee on Tax Supported Medical Care reported on the progress of its activities and those of its subcommittee. Discussions have been and are being carried on with the Mass. Rate Setting Commission for Medicaid payments to physicians. A timetable has been outlined by the Commission for consideration of the matter, but this seems to be drawn out and the question of delaying tactics is being raised. The completed report of Arthur D. Little, Inc., entitled "Physicians' Fees in Mass. 1970 with Implications for Medicaid" has been submitted to the Rate Setting Commission on September 17th. This report was made available to all Councilors at the meeting. It was further announced that on August 18th, Governor Sargent signed legislation which eliminates the requirement for submitting a duplicate bill to the Medicaid recipient. Furthermore, the 90 day rule has been extended to six months. This legislation is retroactive to October 1, 1968.

The Council meeting was adjourned at 3:07 P.M.

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HIGHLIGHTS OF THE OCTOBER EXECUTIVE COMMITTEE MEETING

The Executive Committee met on Tuesday, October 20, 1970 in the Conference Room of the HDMS. The meeting was called to order by Dr. Turner at 8:10 P.M.

Present were: Drs. Turner, Fisher, Bandeian, Moore, Gilchriest, Kelly, Mozden, McHugh, and Mrs. Purdy. The minutes of the September meeting were read and approved by the Committee.

Dr. Wakstein, Regional Administrator for Mental Retardation, attended the meeting to discuss the Proposal for Capital Outlay for the Joseph P. Gentile Springfield Regional Center for the Mentally Retarded. Dr. Wakstein gave the Office and the Mental Health Committee a copy of the entire proposal. Dr. Wakstein expressed the hope that the HDMS would be involved and interested in the proposal and the center. Dr. Wakstein was excused with thanks.

The CVHPC, Inc., wrote thanking HDMS for the pledge of $500.

COMMITTEE REPORTS

Dr. James Allan, Legislative Councilor, sent in an excellent report which was concerned with this year's elections. This report was printed in the October, 1970, issue of *The Hampden Hippocrat.*

OLD BUSINESS

Dr. Memery, Chairman of the Bylaws Committee sent the proposed change made by the committee about the Interhospital and Community Health Planning Committee, making this a standing committee. (page 29, *Hampden Hippocrat,* November issue.) This will be printed in its entirety and voted upon by the membership at the December District meeting.

The Western Massachusetts Heart Association confirmed the date of April 27, 1971 for the program to be held on cardiopulmonary resuscitation with Dr. Milton Alpert as speaker.

Dr. Hough's letter written to Mr. Collins of the Urban League about Senator Brooke's summer program was read. The Committee commended Dr. Hough for such a fine report.

Dr. Allen Johnson's suggestion "that

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the Treasurer be authorized to collect the cost of the meal from each Senior Fellow at the time of attendance at the District meetings" was discussed. After discussion and advice from Dr. Moore, it was felt that if a Senior Fellow wishes to pay for his dinner on a voluntary basis, he may do so.

The Springfield Hospital Medical Center's Emergency Ward had asked for extra help from the physicians stationed at Westover Air Force Base. Colonel Stuart, Hospital Base Commander, insists that letters be written on an individual basis for each physician and must be signed by the Secretary of the HDMS. Letters to this effect for seven interested physicians will be written by Dr. Zacarian and sent to Colonel Stuart.

A follow-up letter from the Greater Springfield Pediatric Society concerning plans for Senator Brooke's program for 1971 was read as informational and confirmed the phone call from Dr. Blake. This was written in the minutes of the September Executive Committee meeting.

NEW BUSINESS

A report was given on a new insurance contract for the City of Holyoke's employees as issued by the Connecticut General Insurance Company. The Committee decided that the Insurance, Labor Relations and Industrial Accident Committee should study this new program and bring back a report to the Executive Committee.

Mrs. Purdy reported that during the past month seven meetings had been held in the offices. She has attended meetings on Model Cities, President's Conference in Framingham, Council meeting, the Hartford County Medical Association meeting with Dr. Turner and a weekend meeting in Boston on peer review.

The Western Massachusetts Heart Association asked for approval of their suggested heart sounds screening testing to be done in schools. This testing is done on first graders and fifth graders to detect heart murmurs that may have organic significance. The Executive Committee gave approval of this program.

The meeting was adjourned at 10 P.M.

The Grievance Committee met and reviewed five cases.

The meeting was adjourned at 10:40 P.M.

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BYLAWS COMMITTEE

After due consideration of the Executive Committee's proposal that the Inter-hospital and Community Health Planning Committee be made a standing committee, the Bylaws Committee recommends that the HDMS adopt the following addition to CHAPTER VII (COMMITTEES) as follows:

Section 19 Inter-hospital and Community Health Planning Committee

This committee shall consist of a chairman and the Vice President or President-elect of the medical staff of each hospital in the District. The President shall appoint all members of this committee.

(a) It shall concern itself with inter-hospital problems and community health planning.

(b) It shall concern itself with the relations between the members of the Society and hospitals.

(c) It shall establish a guide to be followed in the event a member of the Society is threatened with loss of his appointment or curtailment of his hospital privileges.

This addition to the bylaws is to be voted upon at the next duly called meeting of the HDMS, which is to be held on December 8, 1970.

Harry N. Memery, M.D.
Chairman, Bylaws Committee

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